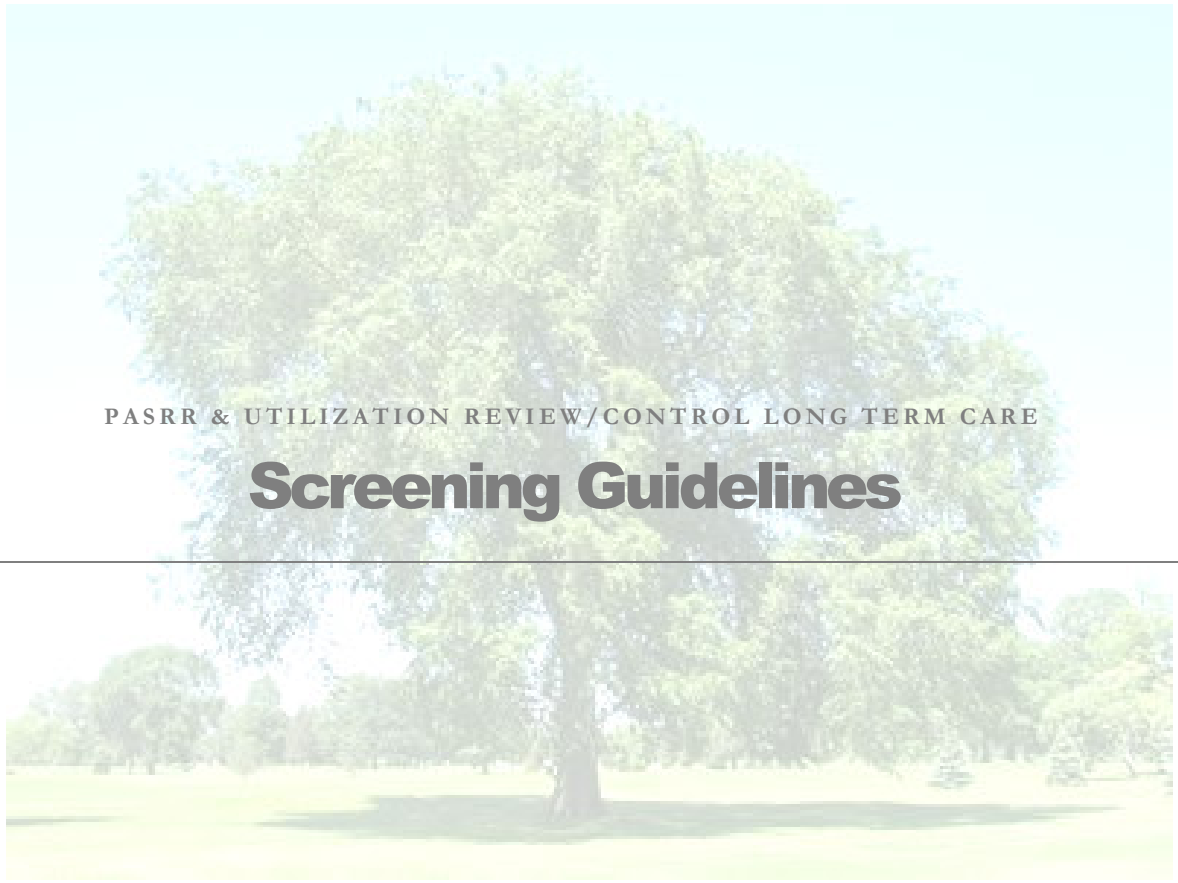
Screening Procedures for Long Term Care Services



PASRR & UTILIZATION REVIEW/CONTROL LONG TERM CARE

Screening Guidelines

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Section 1

Introduction and Overview

Introduction to Dual Diagnosis Management and our role in North Dakota's Long Term Care Screening Processes

This manual serves as a reference for Long Term Care Providers, such as nursing home, hospital, and social service staff, regarding state and federal screening requirements for North Dakota Long Term Care (*LTC*) services, including:

- *Preadmission Screening and Resident Review (PASRR) Level I Screens and Level II Evaluations* - Applies to applicants and residents of Medicaid certified nursing homes, **regardless of the individual applicant's or resident's method of payment.**

- *Long Term Care Medical Necessity Screening* – Applies to all North Dakota **Medicaid eligible individuals** applying to or receiving Long Term Care nursing facility or waiver services as part of the Medical Assistance (*Medicaid*) Admission and re-certification requirements as well as applicants and residents subject to PASRR (regardless of method of payment).

ICON KEY
Valuable information
Make Note
Key Review Points

In the following sections, we provide you with a description of screening requirements, screening processes, and important definitions that you will need to know in order to comply with these program requirements. Both PASRR and Medicaid screening requirements advocate for the individual, through promoting the least restrictive and most appropriate placement at the earliest possible time.

Dual Diagnosis Management

Dual Diagnosis Management (DDM) is a Nashville based utilization review firm that specializes in integrated disease management directed at both behavioral and medical health care. Our staff has solid familiarity with Long Term Care review processes, including level of care and PASRR screening, in North Dakota as well as in a variety of states.

DDM Contact Information

Screening information can be forwarded by facsimile, mail, phone, email, or soon, by web-based submission. All phone and facsimile numbers are toll free. Contact information is as follows:

Dual Diagnosis Management
North Dakota Division
220 Venture Circle
Nashville, Tennessee 37228
Phone: 877.431.1388 • *Facsimile:* 877.431.9568

DDM conducts both phone-based and on-site reviews and evaluations. **Phone-based** reviews are performed within 6 business hours from referral and include *level of care decisions* and *Level I screens*. **On-site evaluations** are performed within 5 business days from referral for nursing home residents who do not appear to meet criteria for nursing home level of care (*potential resident denials*) –and- for nursing home applicants and residents with mental illness as part of *PASRR Level II evaluations*. Both the phone reviewers and the onsite evaluation staff are credentialed and trained employees of DDM.

Hours of Operation

DDM reviewers are available Mondays through Fridays, between the hours of 8:00 until 5:00 Central Time, with the exception of North Dakota State holidays.

N O T E S N O T E S N O T E S N O T E S

Section 2

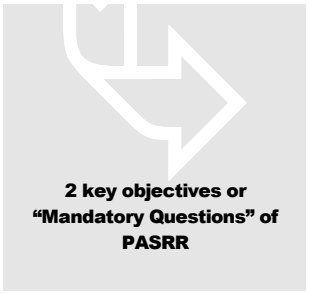
Preadmission Screening and Resident Reviews (PASRR)

Identification and Screening Requirements for Individuals Subject to PASRR

The PASRR *(Preadmission Screening and Resident Review* – **initially PASARR evaluations included *annual* reviews***)* process is a product of broad sweeping nursing home reform that originated in the 1980's from a Congressional initiative directing CMS (then HCFA) and the GAO to investigate nursing home quality. The catalyst was a combination of concerns regarding psychopharmacologic restraints, poly-pharmacy, and quality of care issues in nursing homes. Subsequent investigation identified a high number of "trans-institutionalized" residents – those moved from psychiatric hospitals to nursing facility (NF) care during the *deinstitutionalization* movement. The CMS funded Institute of Medicine (IOM) study also reported widespread quality problems and recommended strengthening Federal regulations to address patients' rights, quality of care, and quality of life. A GAO (1987) report corroborated the IOM findings, citing more than one third of nursing homes operating at a level below minimum Federal standards. As a result, the Omnibus Reconciliation Act of 1987 (OBRA-87), known as the *Nursing Home Reform Act,* mandated broad-spectrum reform in the nursing home industry.

The primary goal of the PASRR program is to advocate for nursing home applicants and residents with disabilities.

These efforts, for the first time, clarified the nursing home industry's responsibility for addressing behavioral health needs of residents, and a portion of that reform required that residents with MI, MR, and conditions related to Mental Retardation (referred to in regulatory language as *related conditions)* participate in comprehensive Preadmission Screening and Annual Resident Review evaluations (PASARRs) to assess:



2 key objectives or "Mandatory Questions" of PASRR

- **Whether the individual requires the level of care provided in an institutionally based setting** and, if so, whether an NF is the appropriate institution.
- **Presence of behavioral health treatment needs**. For residents exhibiting *active,* or *specialized, treatment needs,* the state authority was determined as responsible for providing that treatment.

Routine and ongoing *rehabilitative treatment needs* were determined to be the responsibility of the NF following their identification through the PASARR process.

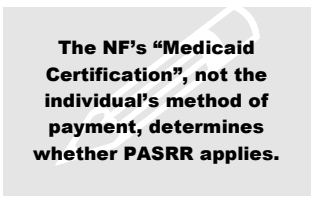
PASARRs were referred to as Level II evaluations to distinguish them from their counterpart *Level I* screens, **where Level I screens are an identification process** for Medicaid certified nursing homes to identify residents subject to the Level II. The Level I is a brief screening tool to identify people with MI, MR, and related conditions. Once an individual is identified, a Level II evaluation must be performed to determine whether the individual has special behavioral health treatment needs.

In October 1996, the *Annual* portion of Level II evaluations was repealed, re-naming the project *PASRR,* through Public Law 104-315. Federal regulations for PASRR can be found in 42 CFR §483.100-§483.138, the *Federal Nursing Home Reform Act* of 1987 (*Omnibus Budget Reconciliation Act, OBRA, of 1987*), and Subtitle C of Public Law 100-203. Federal guidelines for implementing PASRR requirements can be found in the September 26, 1991 *Requirements for Long Term Care Facilities* and November 30, 1992 *PASARR Requirements.*

PASRR Impact

Although unable to separate the effect of PASRR from other reform components (i.e., the RAI and OBRA 1990 LTC requirements), a pre- and post- OBRA-'87 analysis of more than 250 NFs in 10 states identified meaningful improvements in NF treatments (*Phillips, Hawes, Morris, & Fries, 1994*). Decision making through the reform process has also been supported through a variety of legal decisions, such as the June 1999 Supreme Court position regarding Tommy Olmstead v. L.C. and E.W. (The *Olmstead Decision*) which supported ADA mandates of *"the most integrated setting appropriate*" for people with mental or physical disabilities and required "*community-based treatment for persons with mental disabilities when the state's treatment professionals determine that such placement is appropriate.*" In keeping with the Olmstead decision, assessment procedures must maintain a focus on identifying the most integrated appropriate setting.

The Level I Purpose and Components



The NF's "Medicaid Certification", not the individual's method of payment, determines whether PASRR applies.

The Level I screen and, as applicable, level of care screen, is completed within 6 business hours of submission to DDM. The purpose of the Level I screen is to identify those individuals intended for evaluation through the PASRR Level II process, *i.e.,* those individuals with known or suspected MI, MR, and conditions related to Mental Retardation. A copy of the

completed *Level I screen* and *LOC* determination letter will be mailed to the admitting facility. This letter and the *Level I screen* must be maintained in the resident's medical record at all times (**Do not remove the Level I during facility chart thinning process**), and a copy may be transferred with the individual if she or he moves to another NF. The Level I portion is applicable only to nursing facility applicants/residents (swing-beds are exempt) and occurs:

- **Prior to admission** to a Medicaid certified nursing facility (regardless of the applicant's type of payment);
- For residents of Medicaid certified NFs experiencing changes in status that suggests the **need for a first-time or updated PASRR Level II evaluation** (referred to as a "**status change**");
- **Prior to the conclusion of an assigned time limited stay for individuals with MI, MR, and/or RC** whose stay is expected to exceed time limited provisions.

Level I screens **do not apply to** the following individuals:

- **Re-admitted NF residents following hospital treatment**. If there was a significant change in status for an individual with MI, MR, and/or RC, DDM must be contacted following the individual's readmission.
- **Individuals with MI, MR, and/or RC transferring from one facility to another,** (although transfers of residents with MI, MR, and/or RC must be reported to DDM through a *Tracking Form).*
- **Swing bed admissions**.

Circumstances where Level I/II screening *is not* required

The Level of Care form answers one of the 2 *mandatory questions* required for individuals with MI, MR, and RC.

If the *Level I Screen* indicates that the applicant does have symptoms of MI, MR, and/or RC, a *Level of Care Form** must be completed and forwarded to DDM (regardless of the individual's method of payment). **If the individual with MI, MR, and/or RC meets criteria for nursing facility level of care, she/he will be referred for a Level II PASRR evaluation**, which, then must be completed prior to the individual's admission to a nursing facility. If the applicant does not meet NF level of care, it is a federal requirement that NF admission cannot occur (again, regardless of his/her method of payment). Nursing home residents who do not appear to meet nursing home level of care criteria, along with nursing home applicants for whom that decision is inconclusive, will be evaluated on-site by a DDM nurse evaluator or a Regional Developmental Disabilities (DD) staff member.

The Level I screening form includes *trigger* questions to identify those individuals who may meet criteria for serious mental illness, Mental Retardation, or related conditions. These **trigger questions are required federally** as a method for looking beyond the individual's diagnosis

to ensure that individuals *suspected of* having one or more of the three mandatory conditions (MI, MR, and Related Conditions) are identified. Once identified, **the individual with MI, MR, or a Related Condition may require a comprehensive onsite Level II evaluation, an abbreviated (categorical) evaluation or may be exempted altogether from the Level II process.**

The following subsection describes the three groups targeted through this process, along with a description of possible outcomes. *Appendix A* provides a detailed explanation of how to complete the Level I Screen.

Individuals Targeted through PASRR

There are three groups of individuals targeted for evaluation through the PASRR process. Those include individuals with any one or a combination of the following: serious mental illness, Mental Retardation, and conditions related to Mental Retardation.

MENTAL ILLNESS

The federal definition for mental illness is designed to include individuals with a potential for and history of episodic changes in treatment and service needs. Federal guidelines include a three component definition that includes:

- **Diagnosis** of a major mental illness, such as Schizophrenia, Schizoaffective Disorder, Bipolar Disorder, Major Depression, Panic Disorders, Obsessive Compulsive Disorder; -and- the individual does not have a primary diagnosis of Dementia*; and

- **Duration:** *Recent Treatment,* related to significant disruption or major treatment episodes within the past two years and due to the disorder. This might include at least one episode of hospital care for a mental disorder within the preceding two years -or- significant life disruption related to the disorder; and

- **Disability:** referred to as *Level of Impairment* in regulatory language, is characterized by active psychiatric symptoms within the preceding six month period and related to interpersonal functioning, concentration/pace/persistence, or adaptation to change;

***Note about Dementia**

This means that a person with Dementia, who has no other mental health conditions, is excluded from further evaluation through PASRR. On the other hand, a person who has both Dementia and another behavioral health condition (Psychiatric or MR) is not necessarily excluded from further review – The exclusion **can only occur if the Dementia** diagnosis **is primary** over (and more progressed than) the other mental health diagnosis. When co-occurring diagnoses are present, Federal guidelines are very strict that an exemption cannot occur unless sufficient evidence is present to confirm the progression of the Dementia. The kinds of information helpful to establishing primary Dementia (when it co-occurs) include: a neurological assessment, mental status examinations, CT scans, and any other tests that establish

that symptoms of disordered memory and orientation are associated with progressed Dementia.

PASRR is not designed to target:

- People with episodic or **situational emotional conditions**;
- People prescribed **psychoactive medications for non-psychiatric conditions**;
- Swingbed candidates;
- People needing **temporary (30 or fewer days) nursing home stays**, such as those convalescing from hospital stays;
- People admitted to facilities that do not participate in the Medicaid program (**non-Medicaid funded facilities**);
- People with **co-morbid Dementia and mental illness when the Dementia is late stage** or the basis for substantial functional impairments, including reality testing and other executive functioning.
- People who are **transferring or being readmitted** as long as the initial Level I screen is still valid –and- there has been no significant change in status.

MENTAL RETARDATION

Criteria for identifying Mental Retardation is provided in the *Diagnostic and Statistical Manual, Fourth Edition Revised* with the diagnosis based on combined analysis of cognitive and adaptive functioning, with: *Significantly sub-average intelligence (IQ of approx. 70 or less) with concurrent impairments in adaptive functioning and onset before age 18*. Causes can be heredity (PKU) or can be a result of embryonic development (Down's syndrome, anoxia, toxins), medical problems (lead poisoning), or psychological problems (severe deprivation). Levels of MR include:

- *Mild:* IQ approx. 50-55 to 70, accounts for 85% of all cases of Mental Retardation
- *Moderate:* IQ approx. 35-40 to 50-55
- *Severe:* IQ approx. 20-25 to 35-40
- *Profound:* IQ approx. below 20-25
- *Unspecified:* When there is a strong presumption of Mental Retardation but the person's intelligence is un-testable by standard tests.

Key challenges are confirming that lowered cognitive levels are developmentally related and do not result from other medical causes (e.g., stroke, TIA, accidents or injuries) during adulthood. Because formalized testing was less normative in rural areas for elderly individuals with MR, a key challenge is to research developmental information and medical history to confirm developmental onset if that has not been done previously.

RELATED CONDITION/DEVELOPMENTAL DISABILITY

Related Condition (RC) refers to individuals with service or treatment needs similar to individuals with Mental Retardation. **RC is a federal term** whose definition is very **similar to developmental disability**. Persons with related conditions relates to individuals who have a *severe, chronic disability* that meets all of the following conditions:

- Is attributable to cerebral palsy, epilepsy or any other **condition**, other than mental illness, **found to be closely related to Mental Retardation** because this condition results in impairment of general intellectual functioning or adaptive behavior similar to that of people with mental retardation and requires similar treatment or services.
- It is present **prior to age 22**
- Is expected to **continue indefinitely**
- Results in **substantial functional limitations in three or more of the following major life activities:** self-care; understanding and use of language; learning; mobility; self direction; capacity for independent living.

Level II Evaluation Process

Abbreviated Level II (Categorical) Decisions & Exemptions

To determine if a Level II is required, DDM may request medical records information from you.

Once and if an individual is determined to meet standards for one of the three Level II conditions, the next decision is to determine whether a comprehensive onsite Level II evaluation should be performed or, instead, whether the individual might be eligible for an abbreviated (referred to as *categorical* Level II) evaluation or an exemption from the Level II process. An **exemption** means that certain situations or conditions, while also meeting criteria for Level II evaluation, do not warrant that process. Very often, copies of medical records will be needed in order for us to make these decisions.

EXEMPTIONS

Options for exempting an individual from a Level II evaluation include:

An Exemption means a Level II is not required, even though the individual is suspected or confirmed as having MI, MR, or RC.

- **Convalescent Care:** A temporary stay, **physician certified as 30 or fewer days**, for an individual admitted from a hospital to a NF to convalesce **specifically for the condition in which s/he was hospitalized.** If the individual is determined to need nursing home care beyond the 30 day period, and as soon as that decision occurs, s/he must be evaluated through the Level II process. Contact with the screening agency must occur before the 30th day.

- **Primary Dementia/Secondary Mental Illness:** Despite co-morbidity of serious mental illness and Dementia, the Dementia condition has progressed and is primary. *See page 6.*

CATEGORICAL DETERMINATIONS

A categorical decision means that an individual with confirmed or suspected MI, MR, or RC, because s/he fits into a certain *category,* can have an abbreviated Level II assessment.

There are also several circumstances by which an onsite Level II can be bypassed or, because of the individual's fit into a certain *category,* an abbreviated Level II evaluation can be performed at the Level I phase. The federal intent behind **Categorical decisions** was to permit an uninterrupted admission for an individual needing an expedited Level II evaluation. *By virtue of belonging in a certain category, decisions can be made to permit nursing home admissions and to determine that specialized services are not needed for individuals in those categories.* In some cases, a categorical decision means that the individual may still be subject to an evaluation following admission; in other cases that categorical decision stands on its own. **Categorical** Level II determinations can occur for:

- **Provisional Admissions in cases of delirium:** This means that the individual's cognitive status could not be evaluated as a result of delirium, regardless of the presence or absence of a Level II condition. As such, the individual may be admitted and evaluated once the delirium clears. The provider is permitted **up to 7 calendar days** following admission to initiate the remaining assessment components. This screening type requires follow up Level I/LOC procedures for an update at such time that the delirium clears and no later than the 7th calendar day following admission.

- **Type I Provisional Emergency:** This means that the individual has been identified as having MI or MR/RC and there is an urgent need for placement. Generally applied for crises situations (e.g., loss of a caregiver, loss of a residence, etc.) the Division's admission standards require:

  a) **A sudden and unexpected need for placement**, and;

  b) **No other placements are available**.

To obtain a provisional approval, the facility must complete the Level I/LOC screens within 2 working days of the emergency admission. The NF must convey the nature of the emergency which DDM, in turn, must report to the Division's claims processing division for payment determination. Under this standard, the individual is permitted to remain for **up to 7 calendar days** regardless of the outcome of the Level I/LOC screening process. If the individual is determined to need nursing home care beyond the 7 day period, and as soon as that decision occurs, the facility must update the Level I/LOC processes with DDM. If determined not to meet NF criteria, s/he must be discharged by the 7th calendar day from admission.

ON SITE LEVEL II EVALUATIONS

Preadmission Screen (PAS) *Level II evaluations* must occur prior to admission and are completed within seven to nine business days from referral for a *Level II evaluation,* although we strive for a five business day average. Resident Reviews (RR) occur when there is a Change in Status (refer to the following page). DDM completes MI Level II PASRRs, and Regional DD staff complete MR/RC PASRRs. Patient records for *MR/RC Level II evaluations* should be sent to the Regional DD Program Administrator and, once a referral is made for a MR/DD evaluation, the Regional DD Coordinator will make a final determination regarding the need for a *Level II PASRR evaluation.*

When symptoms/history of mental illness indicates that a *Level II evaluation* is needed, DDM will coordinate an on-site *Level II PASRR evaluation.* The referral source will be asked to send the following patient records to DDM for *MI Level II evaluations.*

- A current **history and physical** (performed within the past 12 months) that includes a complete medical history with review of all body systems;
- A comprehensive **drug history** including, but not limited to, current or immediate past use of medications that could mask symptoms or mimic mental illness; and
- Current **physician's orders** and treatments.

Receipt of this information will initiate a referral for a *Level II PASRR evaluation.* The medical record information and on-site *Level II PASRR evaluation* will be reviewed by Regional Developmental Disabilities staff for *Level II MR/RC evaluations.* The Regional Developmental Disabilities Coordinator will notify the referral source (e.g., NF, hospital, applicant, guardian) of the *Level II MR/RC* determination. DDM notifies the referral source (as above) of the *Level II MI* determination by telephone within seven business days following the receipt of the individual's records from the referral source. A formal notification letter will be sent to the referral source.

The receiving nursing facility notifies DDM of the individual's date of admission by faxing the *Tracking form*. Upon its receipt, DDM forwards screening results to the admitting facility.

Level II Outcomes (Determination & Notifications)

When the *Level II PASRR evaluation* is completed, the applicant will become part of the PASRR

population and their placement will be tracked regarding their location within the nursing facility network. This process is continuous until they exit the PASRR population.

LEVEL II APPROVALS

An *Approval* indicates that the NF placement is appropriate. There are three (3) types of Approvals.

- **Applicant is appropriate for NF** placement/services.
- **Applicant meets NF LOC criteria but requires inpatient psychiatric treatment** to address their psychiatric needs before they are placed in the nursing facility.
- **Applicant is appropriate for short term NF placement**. Short term stays are time-limited and only apply to Medicaid recipients.
- **Applicant does not have a MI or MR/RC.** If s/he is a Medicaid recipient, a LOC determination will be provided for short or long-term stay. If the individual is not a Medicaid recipient, neither PASRR nor LOC screening applies.

LEVEL II DENIALS

A Denial indicates that NF placement is **not** appropriate. There are two (2) types of Denials.

- **Applicant does not meet minimum LOC** standards.
- **Applicant is not appropriate for NF placement** due to the need for special behavioral health services.

NOTIFICATION PROCESS

DDM staff will call the referring individual as soon as the assessment is complete, followed by documentation of the assessment outcome and, as applicable, appeal rights to the individual/legal representative. A notification letter and a *Summary of Findings Report* will also be forwarded to the admitting facility, following receipt of admitting information (either by telephone or through receipt of the *Tracking Form).*

The notification letter and the *Summary of Findings Report* must be maintained in the resident's medical records at all times. If the individual transfers to another NF, a copy must be transferred to the new NF placement. As appropriate, these reports identify any behavioral health treatment and service needs that are the responsibility of the NF staff, as well as specialized treatment needs that must be delivered by specialized providers. These determination reports work in conjunction with the facility's resident assessment process to define a holistic care plan for the resident.

If admission is denied, written notification will be forwarded to the individual and his/her legal guardian, along with appeal rights through the fair hearing process.

Change in Status Process

Whenever the following events occur, nursing facility staff must contact DDM to update the Level I screen and discuss whether a (first-time or updated) Level II evaluation must be performed. These situations suggest that a significant *change in status* has occurred:

- **If a resident with MI, MR, and/or RC experiences a significant physical status improvement**, such that she/he is more likely to respond to special treatment for that condition **or** she/he might be considered appropriate for a less restrictive placement alternative.

- **If an individual with MI, MR, and/or RC was not identified at the Level I screen process, and that condition later emerged or was discovered.** The facility should monitor data on the MDS to identify a mental disability.

- **If the resident previously discovered with MI, MR, and/or RC should exhibit increased symptoms or behavioral problems.**

- If a *Level II PASRR evaluation* of an individual resulted in a decision requiring inpatient psychiatric treatment and, **following delivery of inpatient psychiatric services, an update to the Level II is needed to confirm appropriateness of NF.**

- **If an individual with MI, MR, or RC who was approved under a time limit is expected to stay beyond the approved timeframe**. This would apply to individuals approved under Convalescent Care (30 day maximum approval), Emergency Type I (7 day maximum approval), and Delirium (7 day maximum approval) decisions.

- **If an individual with MI, MR, or RC is transferred, discharged, or expired.** This can be reported through a *Tracking Form* to DDM (for residents with MI) and the Regional DD Administrator (for residents with MR/RC).

Status Change Quality Monitoring Process

When federal regulations eliminated Annual Resident Reviews, legislation placed increased emphasis on states to ensure a system of managing and monitoring significant status changes of NF residents with MI, MR, and/or RC. NF staff must report status changes according to procedures described above. The following process monitors NF staff compliance with those reporting requirements:

- NF staff forward *Tracking Forms* to DDM to report admissions/transfers of residents with MI and to Regional DD staff to report those changes for individuals with MR and/or RC.

- Concurrently, during routine Quality reviews of *Level II PASRR evaluations*, DDM

staff flag residents with heightened potential for significant status change. Once admission information is forwarded through the *Tracking Form,* DDM staff performs follow-up phone interviews with NF staff for these individuals. During that phone conversation, DDM will ask questions and solicit medical records information to monitor for psychiatric and medical changes and determine need for further assessment through the Level II.

- NF staff is required to supply any needed medical records documentation to aid in these interviews and update resident medical/mental status information.

- The results of these activities will be routinely reported to the North Dakota Department of Human Services.

 **Anytime a NF resident with MI or MR/RC experiences changes that affect his/her placement or service decision (suggesting the need for a less restrictive placement or more intensive behavioral health services), NF staff must contact DDM to report that change.**

 **Level I/II Screening results remain valid for the individual's stay in a NF, unless a change in status (described above) occurs.**

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Section

3

Medicaid Level of Care Screening

Level of Care Screening Requirements for Individuals who are Medicaid Eligible Individuals –and- for NF Applicants/Residents Subject to PASRR

The Level of Care process is directed at determining medical need for long term care services for **two** populations:

- **To determine need for long term care services for individuals who are Medicaid eligible**. Long Term Care services include NF, swingbed (SB), and Home and Community Based Waiver programs (HCBS for aged and disabled and Traumatic Brain Injuries) Level of Care reviews are also mandated for any North Dakota Medical Assistance recipients entering/residing in Minnesota NFs; and

LOC Screens apply to Medicaid eligible individuals using LTC services
–And-
All NF applicants & residents with MI, MR, and RC.

- **To determine level of care needs for NF applicants and residents with MI, MR, and RC, regardless of method of payment, as part of federally mandated PASRR requirements**. For PASRR purposes, the *Level of Care screen* is performed prior to admission and whenever a resident with MI, MR, and/or RC experiences a significant status change as described in the **Change in Status Section.**

The Level of Care Purpose and Components

The Level of Care Screen is completed within 6 business hours of submission to DDM. A copy of the completed *LOC* determination letter will be mailed to the admitting facility or social service program, as appropriate. This letter and the *LOC Screen* must be maintained in the resident's medical record at all times (**Do not remove the Level of Care during facility chart thinning process**). If the level of care is applicable at time of transfer from NF to NF (*e.g., an approved LOC screen occurred within 90 days and the individual's medical and treatment needs have not changed*), a copy of the screen must be transferred with the individual. The LOC Screen occurs for the following:

- **Medicaid eligible NF/SB *Applicants*** (also applies for individuals who are eligible for both Medicare and Medicaid).

- **ND Medicaid Eligible NF Applicants/Residents in Minnesota NFs**: Because of a reciprocity agreement with Minnesota, ND is the responsible payer for two years for these individuals. Therefore, all screening requirements described in this manual apply.

- **Medicaid eligible NF/SB *Resident Continued Stay Review***: Occurs for individuals whose prior level of care determination indicated heightened potential for medical improvement/potential for discharge to a less restrictive placement. **This includes individuals approved under Type II Emergency approval** (see *Emergency Type II Admissions* later in this section*).*

- **Medicaid eligible NF/SB *Resident Medical Status Change***: When a Medical Assistance resident's medical status improves to the extent that she/he no longer meets eligibility criteria.

- ***Applicant* with MI, MR, and/or RC**: As part of PASRR requirements. This **includes LOC updates** for individual with MI, MR, and/or RC approved **for time-limited admissions** and expected to stay beyond that time limit.

- ***Transfer of NF or SB Resident* with Medical Assistance**: Prior to NF/SB transfers for Medical Assistance recipients **if an approved LOC screen wasn't performed within 90 calendar days** of date of transfer – and- medical & treatment needs have not changed.

- ***Change in Payment* Status**: When a private pay NF/SB resident converts to Medical Assistance.

- ***Administrative* screen**: for expired or discharged individuals whose Medicaid eligibility was not known at death/discharge, to determine a retroactive eligibility date.

- ***HCBS and TBI Service Applicants/Recipients***: Initially and annually for Home and Community-Based Service (HCBS) and Traumatic Brain Injury (TBI) Waiver recipients.

LOC Screens are not required for the following individuals:

a. **Private pay NF applicants/residents without diagnoses or suspicion of MI or MR/RC** (per *Level I screen*).

b. **Private pay swing-bed applicants/residents**.

c. **Basic care facility residents/applicants**.

d. **Residents transferring from NF/SB to another NF/SB who have had approved LOC screens within 90 calendar days**.

Circumstances where LOC screening *is not* required

e. **Re-admissions to the same NF following treatment in a hospital.** If the hospitalization resulted from a significant status change, an updated screen may be required following readmission.

Emergency (Type II) Admissions

***Type I* Emergency applies to individuals <u>with</u> MI/MR as a crisis placement. *Type II* applies for NF applicants <u>without</u> MI/MR (and all SB applicants) when urgent placement is needed and screening services are unavailable.**

Type II is an emergency admission standard for individuals applying to NF or SB under certain circumstances. *Note that the criteria for Type II emergency differs from the PASRR Type I emergency.* While *Type I* applies to applicants with MI, MR, and/or RC, the Emergency Type II definition is provided for Medical Assistance applicants without MI, MR, and/or RC. Emergency Admission (Type II) applies to:

- NF applicants without evidence/diagnoses of MI or MR/RC; and

- SB applicants regardless of presence/absence of MI, MR, and/or RC.

Admissions under Type II are permitted in the following situations:

- Based on the individual's physical and/or environmental status, there is a **sudden and unexpected need** for immediate NF/SB placement; and

- The above need is **discovered with less than one (1) business day** within which to expedite appropriate screens with the screening agency and **efforts to reach the screening agency were unsuccessful or impossible** (e.g., weekend, evening, holiday); and

- The individual is **determined by the receiving facility to meet minimum LOC** criteria for NF/SB care; and

- There are **no other viable placement options** available until the next business day.

Under emergency standards (*Type I* and *Type II*), the facility must complete appropriate screens with DDM within two (2) business days of the emergency admission. The NF/SB must convey reasons for the emergency admission to DDM who will, in turn, report emergency admissions to claims processing to allow retroactive Medicaid payments to admission.

Admission Process & Outcomes

At the conclusion of the document-based NF/SB LOC screen, one of the following outcomes will occur:

- **Long Term Approval:** Review information indicates the individual's needs qualify for NF/SB LOC on a long-range basis. No additional review date shall be established.

- **Short Term Approval:** Review information indicates the individual's needs qualify for NF/SB LOC on a short-range basis of three (3) to six (6) months and no greater than a six (6) month time frame (e.g., short range restorative procedures). An appropriate *CSR* point shall be established and the individual will be entered into DDM's tracking database with the attendant tracking time frame. At the conclusion of the assigned time frame, CSR procedures will be implemented.

- **Denial:** If the individual's needs do not meet NF/SB LOC, Medicaid will not pay for admission to a NF/SB.

- **Level II Required (NF only):** If the individual is suspected or known to have MI or MR/RC, a Level II evaluation must be performed before admission to a Medicaid certified NF can occur. The DDM nurse reviewer will determine whether the Level II must be performed onsite and, if so, **the individual cannot be admitted until the Level II process is complete.**

Determinations of level of care decisions will be reported to the referring agency within 6 hours of DDM's receipt of (completed) screening information. Written notification will be forwarded within 48 business hours of the decision to the individual (or legal

representative) and the referring agency. For adverse decisions, notifications include a process for appealing the decision.

Continued Stay Review (CSR) Process

The Continued Stay Review (*CSR*) is a re-evaluation of medical and nursing needs for NF/SB residents who exhibit potential for discharge to a less restrictive level of care. The CSR begins with a document-based, updated Level of Care screen. If that screen suggests that the resident no longer meets NF/SB level of care, the document-based screen will be followed by an onsite evaluation by a DDM nurse. Individuals for whom the CSR applies include:

Whenever a NF or SB resident no longer meets LOC standards, a CSR must be initiated by the NF/SB staff

- **Medical Assistance (or Medicaid Applying) NF/SB residents whose initial review determined potential for medical improvement** to the extent that NF/SB care would not likely result in need for long term placement in that setting; or

- **An individual with North Dakota Medicaid housed in (or relocating to) a Minnesota NF**. On-site *CSRs* shall not be performed on these individuals; however a document-based clinical review will be performed to determine continued need for long term care services.

- **NF residents with MI or MR/RC who experience significant changes in status.** If DDM's review staff concur that a status change is occurring, the individual will be referred for an onsite evaluation by either DDM's ND nurses or the Regional DD Staff.

CSR Process

A CSR may occur for any of the reasons described earlier in this section (e.g., facility request due to medical improvement, Medical Assistance application, etc.). If the CSR is pre-scheduled (meaning that DDM identified a likelihood of medical improvement during a prior level of care screen):

- DDM's reviewer will inform the individual that submits the admission screen of the short term approval.

- The receiving NF/SB sends a *tracking form* to DDM. Upon its receipt, DDM issues a letter to the receiving NF with an end date for the individual's stay.

- The week prior to the designated end date, DDM will contact the NF to coordinate the *CSR*.

- During the CSR, the DDM's review nurse updates the *LOC screen* with NF/SB staff. Supportive documentation shall be solicited from the facility to reflect the individual's current medical and functional status and any nursing needs.

CSR Outcomes

- **Long Term Approval:** Review information indicates the individual's needs qualify for NF/SB LOC on a long-range basis. Continued care will be approved and no additional review date shall be established.

- **Extended Short Term Approval:** Review information indicates the individual's needs qualify for NF/SB LOC on a short-range basis of three (3) to six (6) months and no greater than a six (6) month time frame (e.g., short range restorative procedures). An appropriate *CSR* point shall be established and the individual will be re-entered into DDM's tracking database with the attendant tracking time frame. At the conclusion of the assigned time frame, aforementioned procedures will be repeated.

- **Potential Denial/On-site Assessment Required:** If the individual's needs remain questionable and/or are denied, an on-site review of the individual's medical and service needs shall be conducted by DDM's ND nursing staff.

On-site CSR Process

On-site *CSRs* are performed within five (5) business days of the referral for the on-site review. The following shall occur as part of that process:

- DDM's North Dakota licensed nursing staff shall schedule and conduct an onsite assessment, including a chart review and, as needed, obtain copies of medical records information that clarify medical and nursing needs. These will be forwarded to DDM.

- DDM's physician reviewers will review all assessment information, including any medical records, and make a final determination of the individual's need for NF/SB level of care.

On-site CSR Outcomes

- **Long Term Approval:** The physician review process indicates the individual's needs qualify for NF/SB LOC on a long-range basis. Continued care will be approved and no additional review date shall be established.

- **Extended Short Term Approval:** The physician's review process indicates that the individual's needs support continued qualification for NF/SB LOC on a short-range basis of three (3) to six (6) months and no greater than a six (6) month time frame (e.g., short range restorative procedures). An appropriate *CSR* point shall be established and the individual will be re-entered into DDM's tracking database with

the attendant tracking time frame. At the conclusion of the assigned time frame, aforementioned procedures will be repeated.

- **Denial:** The physician's review process indicates that the individual's needs no longer support continued qualification for Medicaid funded NF/SB LOC.

Determinations of level of care denials through the physician's review process shall be reported to the housing facility within four (4) hours of the physician's decision and by the seventh (7th) business day from the date that the telephonic review resulted in a determination that an on-site *CSR* would be required. Written notification which includes appeal rights shall be forwarded within 48 business hours of the decision to the individual (or legal representative) and the housing facility.

 **If a resident is not determined to require a CSR through the LOC screening process and later improves to the extent that NF/SB level of care may no longer be required, it is the responsibility of the NF to contact DDM to update screening processes.**

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Section 4

General Information

Tracking, Appeals, Quality Management, and Medicaid Payment Alerts

The Tracking Form

The *Tracking Form* is a way for DDM (and the Regional DD Coordinators) and NF/SB providers to communicate with each other for the following purposes:

- **For first time admissions to NFs/SBs.** This alerts DDM to send admission screening information. If a resident transfers and existing screening information is still valid (i.e., LOC screen is under 90 days), copies of screening information, (*Level I and LOC*, as applicable) must be sent by the transferring facility to the receiving NF/SB.

- **For all NF applicants with MI and MR/RC (new admissions, transfers, discharges, and expired residents with MI and MR/RC).** The Department is required to *track* changes in placement for residents with MI and MR/RC. MR/RC tracking information must be sent to the Regional DD Coordinator; tracking information for residents with MI must be sent to DDM.

- **All Residents who expire or leave the NF/SB system altogether.** This allows DDM to close records of residents no longer receiving LTC services.

Appeal Process

The recipient or an authorized representative (e.g. guardian, family member), may appeal adverse decisions. Appeal requests must be in writing and submitted to:

Appeals Supervisor
North Dakota Department of Human Services
Dept. 325
600 East Boulevard Avenue
Bismarck, North Dakota 58505
(701) 328-4864

Quality Management

As required by the Department, DDM must obtain supportive documentation in a variety of situations:

- **To clarify medical status and confirm the individual's LOC needs**
- **To determine whether the individual requires a PASRR evaluation** (either through a status change decision or to clarify whether the individual meets federal criteria for MI or MR/RC).
- **As a periodic random quality check of data integrity**. This request will not delay the telephone review decision, but will provide the information needed to monitor the integrity of the telephone review process.

Requested documents may be sent by mail or by facsimile. DDM staff will review the records submitted and prepare reports reflecting the accuracy of telephone reviews. Consistent facility variance between information given by telephone and medical record documentation may indicate the need for additional training for that facility. If variances persist despite additional training, DDM has the option to terminate telephone-based reviews for that facility.

Medicaid Payment Alert

The facility is responsible for submitting a *Medicaid Payment Alert Form* for Medicaid admissions and for individuals applying for Medicaid to:

Claims Processing
North Dakota Department of Human Services, Medical Services Division
600 East Boulevard Avenue, Bismarck, ND 58505.

This form must be submitted after a LOC determination is obtained. The *Medicaid Payment Alert Form* is required in order to complete county Medicaid eligibility requirements, if applicable, as well as to initiate payment through Claims Processing.

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Section 5

Commonly Used Terms

Applicant - Any individual seeking admission to a Medicaid certified nursing facility in the state of North Dakota or individuals with North Dakota Medicaid who are entering NFs in the State of Minnesota.

Categorical Determinations– Applies to individuals with known or suspected MI, MR, or RC who, by virtue of belonging to a certain category of needs, can be subject to an abbreviated Level II (e.g., need for emergency placement, presence of delirium).

Change of Status (Status Change) - A condition which warrants referral for an updated Level I screen to determine whether an onsite Level II is required. The Minimum Data Set (MDS)/resident assessment process should be monitored to determine any changing or newly identified needs.

Continued Stay Review - Re-evaluation of NF/SB resident with Medical Assistance whose initial review determined potential medical improvement to the extent that nursing facility/swing-bed (NF/SB) care may not be needed long term. Telephonic Continued Stay Reviews, which result in denial of NF/SB level of care, are followed by on-site Continued Stay Reviews which are reviewed by a physician for final determination of level of care need.

Exemption – A situation where an individual with MI, MR, or RC can be excluded from PASRR evaluation (e.g., because of primary Dementia or because s/he meets criteria for convalescent care).

Convalescent Care – An exemption from PASRR. Convalescent Care exemptions can be applied when an individual is transferred from a hospital to a NF for the condition in which s/he was treated in the hospital –and- the attending physician certifies in writing that the individual's stay in the NF is unlikely to exceed 30 calendar days.

Home and Community Based Services (HCBS Waiver) – Medicaid benefits and targeted services and supports offered as an alternative to institutional placement for individuals with defined needs. HCBS Waiver services in North Dakota are offered to individuals with Traumatic Brain Injuries (TBI) and MR/DD, as well as to individuals who are determined to meet criteria for Aged and Disabled.

Level I Screen - An assessment conducted prior to NF admission or when there is indication of a resident's change in status. This screen identifies the presence of serious mental illness, Mental Retardation, or conditions related to Mental Retardation. Swing-beds are exempt from the Level I process.

Level II Evaluation - The Level II evaluation determines whether the individual has special needs due to his/her mental condition that need to be addressed in a nursing facility. It is also designed to determine whether those special needs are so significant that they cannot be met in a nursing facility and can only be met in a psychiatric hospital facility or a specialized facility dedicated to the care of the developmentally disabled. Level II PASRR evaluation must be performed both prior to admission (PAS) and when a resident with MI, MR, and/or RC experiences a significant change in placement or MI, MR, and/or RC service needs. Swing-beds are exempt from the Level II process.

Level of Care Determination (LOC) - An assessment of an applicant or resident of a NF/SB to determine if she/he meets minimum medical necessity requirements for long term care services. A Level of Care screen is also required initially and annually for participants in the Traumatic Brain Injury (TBI) and HCBS waiver programs.

Mental Retardation/Related Condition (MR/RC) - Sub-average intellectual functioning (*mild, moderate, severe, profound*) existing concurrently with deficits in adaptive behavior and manifesting during the developmental period (prior to the age of 18); or a severe, chronic disability whose condition is related to Mental Retardation (see Related Condition).

Referral Source - Person assisting applicant with nursing facility placement (*e.g., hospital discharge planner, nursing facility admissions coordinator, county caseworker, home health worker*).

Related Conditions (RC) - Severe, chronic disability whose condition is: a) attributable to: cerebral palsy or epilepsy; or any other condition, other than Ml, found to be closely related to MR because the condition results in impairment of intellectual functioning or adaptive behavior similar to that of a person with MR and requires treatment or services similar to those required for such persons (e.g., autism); and b) manifested before the person reached age 22; and c) likely to continue indefinitely; and d) results in substantial functional limitations in three (3) or more of the following areas of major life activity: self-care, understanding and use of language, learning, mobility, self-direction, and/or capacity for independent living.

Serious Mental Illness (SMI or MI) - A condition which results in the presence of all of the following: a) DSM-IV-TR diagnosis of a mental disorder which is likely to lead to a chronic disability, excluding a primary diagnosis of Dementia or a related disorder; and b) presence of functional disabilities within the past six (6) months which are inconsistent with the individual's developmental stage/ medical condition and include deficits in one of the following: interpersonal functioning, concentration/task performance, or adaptation to change; and c) treatment history within the past two (2) years which includes either psychiatric treatment that is more intensive than outpatient or supportive services (to include judicial or housing intervention) to prevent the need for more intensive services.

Specialized Services/MI - North Dakota defines specialized services as inpatient psychiatric care.

Specialized Services MR/RC - MR and RC evaluations are referred to the North Dakota Department of Developmental Disabilities (DD) for processing.

Swing-Bed (SB) Admissions - Applicants for swing-bed admission are not subject to Level I screens or Level II PASRR evaluations screens. Prior to admission, a level of care determination must be completed on applicants who are Medicaid recipients or who have applied for Medicaid benefits. Level of care determinations must be obtained on individuals who enter as private pay and apply for Medicaid benefits during their SB stay. These reviews are the same as the Level of Care process.

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Appendix A: Level I Screening Instructions

If the provider (i.e., nursing home or hospital staff) does not know the responses to questions on the form, respond as "unknown" rather than "no".

The *Level I Form* is used to identify individuals who may be subject to a *Level II PASRR evaluation* (those *known or suspected* as having diagnoses of MI, MR, and/or RC). The Level I applies to all Medicaid certified nursing facility applicants and residents, regardless of the individual's method of payment. Swing-beds are federally exempt from this process. This form must be completed on all individuals prior to NF admission and updated when there is a significant change in status in a NF resident (see **Change in Status Section**).This format is consistent with federal program requirements. The majority of screens require only the completion of page 1. Information on page 2 is necessary only for those NF applicants/residents who appear to have MI, MR, and/or RC. For telephone referrals, it is recommended that the referral source complete page 1 prior to initiating contact with DDM, as this will assist in expediting the process. The following instructions should be used as a guide for completion.

PT NAME/SS#/MID

Identify the full name of the applicant/resident, the applicant/resident's social security number, and, the applicant/resident's Medicaid number. Indicate "N/A" if the individual does not receive Medical Assistance benefits. Note "*pending*" if the individual has applied for those benefits.

ADDRESS/CONTACT PERSON

Identify the address and contact person to which correspondence regarding the individual should be directed.

SEX /DOB/COUNTY/PAYMENT STATUS/MARITAL STATUS

Identify the individual's gender as "M" (male) or "F" (female); identify the individual's date of birth, Current County of residence, payment status, and marital status.

SOURCE NAME/ADDRESS/PHONE/FACILITY

Identify the name of the individual referring the applicant/resident for a Level I screen; Identify the address, phone, and the facility at which the referral source is employed.

ADMITTING FACILITY/ADDRESS/CONTACT PERSON/PHONE

Identify the name, address, contact person, and phone for the admitting facility, if identified. If not known or not identified, indicate as "unknown".

PATIENT'S CURRENT LIVING ADDRESS

Indicate the full address of the individual's current residence. If a *Level II PASRR evaluation* is required, this should reflect the location at which the evaluation will occur. If the patient is currently in the hospital, identify the name, address, and room number of that setting.

SECTION I: MENTAL ILLNESS SCREEN

Psychiatric Diagnoses: Check the box for any applicable diagnoses provided in the checklist. If the individual is diagnosed with psychiatric conditions not included in the checklist, write those diagnoses in the space provided.

Psychiatric Medications/Diagnosis/Purpose: Indicate any psychotropic medications (include tranquilizers and antidepressants) that the individual receives routinely. If the individual routinely is prescribed a medication within that drug group and it has been discontinued temporarily (e.g., because she/he is in the hospital), that drug should be noted. Diagnosis/Purpose refers to the condition for which that medication is being prescribed.

DDM Use Only. To be completed by DDM to determine whether, based on information provided by the referral source, the identified diagnosis (es) is consistent with the parameters of the federal requirements for a disabling mental illness.

Psychiatric treatment received in the past two (2) years: Indicate any mental health/psychiatric intervention, which the individual has participated in the previous two (2) years and specific dates for those services.

Inpatient psychiatric hospitalization; and/or

Partial hospitalization/day treatment (participation in a structured, outpatient group program of a least three (3) hours per day for a specified number of days per week); and/or

Note any other alternative mental health/psychiatric services (e.g., psychiatric consultations, group therapy, individual therapy, etc.).

Intervention to prevent hospitalization: Indicate whether, in the absence of psychiatric treatment, the individual has been "at risk" for intense psychiatric treatment because of a mental illness. This criterion asks:

This refers to residence change due to the psychiatric condition, i.e., supported living placement, boarding home, increased monitoring due to suicide attempt, incarceration, etc.

- Has there has been an active psychiatric treatment history more intensive than outpatient (e.g., inpatient, day treatment) treatment within the prior two (2) year period; and/or
- Has there been a serious life disruption during that timeframe (e.g., suicidal thoughts or actions, safety-related or involved behaviors, housing changes due to behaviors associated with MI, judicial intervention due to behaviors associated with MI, and/or other significant episodes) which affected safety to self or others such that involvement of some kind of professional agency was required?

DDM Use Only. To be completed by DDM to determine whether, based on information provided by the referral source, the information is consistent with federal criteria for psychiatric treatment history.

Role Limitations within the past six (6) months that is due to the mental illness: Each of the three (3) categories (3.A. through 3.C.) are to be rated according to their presence/absence within the past six (6) months. In each section determine if there is a disability related to the disorder resulting in major functional role limitations. If the individual presents with some of the symptoms/behavioral problems, not related to a physical condition, and she/he has no diagnosis of mental illness, the problem should still be identified.

Interpersonal Relationships: Circle F, O, or N to indicate frequently, occasionally, or never, respectively. Any behavioral/symptomatic conditions, which are observed by the referral source, facility, and/or family and are not noted in the supplied list, should be written in the space provided.

Concentration/task limitations: This area is rating the individual's ability to concentrate/complete tasks, as impacted by his/her emotional status (not related to physical condition).

Significant problems adapting to typical changes within the past six (6) months and due to MI: Circle Y or N to indicate yes or no, respectively. This area is rating the individual's response to any recent lifestyle changes and whether that response may be indicative of or consistent with a serious mental illness.

DDM Use Only. To be completed by DDM to determine whether, based on information provided by the referral source, the individual's functional status is consistent with a psychiatric disability defined in federal rules. Combined, the responses to questions 1 through 3 will determine whether the individual meets the federal serious mental illness (SMI) definition.

SECTION II: MENTAL RETARDATION AND RELATED CONDITIONS SCREEN

NOTE: This section is assessing for TWO conditions: MR and RC. Because some individuals may have RC without MR, it is very important that all questions in this section be completed.

MR Diagnosis. Check Y (yes) or N (no) to indicate whether the individual is diagnosed with Mental Retardation. Specify whether the level of retardation is mild, moderate, severe, or profound, if known. If this information is unavailable, indicate "UK" for unknown.

Undiagnosed but suspected MR. If the individual has not been diagnosed with Mental Retardation (but such a condition is suspected) or the referral source is uncertain as to whether or not such a diagnosis has been assigned (but suspects that it may be appropriate), the referral source should check "Y" to indicate that suspicion. If l.A. was checked "Y", it will not be necessary to answer l.B., because the suspicion has been confirmed through a diagnosis.

History of receipt of MR services: If the individual has received services from the developmental disabilities region or from other MR affiliates, indicate "Y" and specify the type(s) of services.

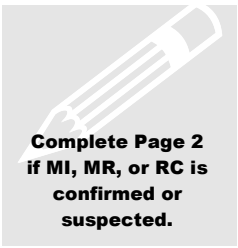
Onset before age 18: Was the applicant/resident's MR diagnosis or suspected diagnosis established prior to the age of 18? If so, specify the age of onset.

Related Condition diagnoses which impair intellectual functioning or adaptive behavior: This question, in addition to questions 3 and 4, is determining whether the individual falls within the parameters of a condition related to Mental Retardation (related condition), meaning that an individual with such a condition may need treatment similar to that of a person with Mental Retardation. There are a number of diagnoses/conditions which are considered to be a related conditions such as cerebral palsy, autism, complicated epilepsy, post encephalitis (prior to age 22), and head trauma (prior to age 22), etc. If the referral source is unsure about a diagnostic inclusion in this category, list any suspected related conditions and DDM will make the determination.

Substantial functional limitations in three (3) or more of the following areas: This question refers to whether the diagnosis (es)/condition has severely impacted functional areas which are similar to the functional impact found with typical MR individuals.

Was the condition manifested before age 22: Was the identified condition congenital or at what age did it occur (e.g., head injury and/or encephalitis)? Individuals whose condition occurred prior to age 22 and who satisfy the criteria for numbers 2 and 3 (above) meet the definition for MR and/or RC, and are eligible for various treatment services provided by the State.

DDM Use Only. To be completed by DDM to determine whether, based on information provided by the referral source, the identified diagnosis (es) is consistent with the parameters of the federal requirements for MR/RC.



Complete Page 2 if MI, MR, or RC is confirmed or suspected.

SECTION III: DEMENTIA

Page 2 determines whether the individual is eligible for an abbreviated document based screen or an exemption from the Level II process. **Page 2 is applicable only for people confirmed or suspected as having MI, MR, or RC conditions.**

Does the individual have a primary diagnosis of Dementia or Alzheimer's disease? This is asking two (2) questions: Does the individual have such a diagnosis? Is that diagnosis primary? The physician should determine whether the dementing condition (if present) is primary, meaning that the Dementia symptoms supersede the symptoms/behaviors of the MI, MR, and/or RC.

Does the individual have any other organic disorders? This is referring to whether there is another organic condition for which the presenting symptoms/behaviors may be attributed.

Is there evidence of undiagnosed Dementia or other organic mental disorders? Although the individual may not be diagnosed with Dementia or a like disorder, this question is asking whether there are presenting symptoms consistent with such a diagnosis.

Is there evidence of affective symptoms, which might be confused with Dementia? It is often very difficult to make a differential diagnosis between Dementia and some psychiatric conditions, which might mimic Dementia (e.g., depression). This question is asking whether some of the presenting symptoms are affective in nature, possibly indicating a potential for confusion between Dementia and another psychiatric condition.

Can the facility supply any corroborative information to affirm that the dementing condition exists and is the primary diagnosis? This information must be confirmed before applying any exemptions or categorical determinations for persons with suspected Dementia. This is primarily to assure that the intended target populations are evaluated as needed and to prevent inappropriate exemption of individuals who have serious MI, which might be confused with Dementia. The types of information required to confirm such a diagnosis are listed.

DDM Use Only. To be completed by DDM to determine whether, based on information provided by the referral source, the individual appears to meet the parameters of primary Dementia. If she/he also has a secondary psychiatric condition, DDM's reviewer may halt the process at this point. If the individual also has MR/RC, the process should continue. The regional DD staff will determine whether an on-site Level II PASRR evaluation is required.

SECTION IV: CONVALESCENT CARE EXEMPTION

Convalescent care allows the individual with MI, MR, and/or RC to be placed in a NF for 30 calendar days without performance of a *Level II PASRR evaluation*. However, several provisions apply and all of these must be met before the individual may be admitted under this exemption (see below). It is the receiving facility's responsibility to re-establish contact with DDM prior to the conclusion of the 30 calendar days, and no later than the 25th calendar day, to update the individual's *Level I* and *Level of Care screens*.

Does the individual meet all of the following criteria?

- ***Admission to a NF directly from a hospital:*** The individual must be in the hospital at the time of application; and

- ***Need for NF care is required for the condition for which care was provided in the hospital;*** and

- ***The attending physician has certified prior to admission that the individual will require less than 30 calendar days NF care*** (clearly, an individual whose medical condition will require longer than 30 calendar days to stabilize will not be eligible for convalescent care [e.g., broken hip]) and should not apply for this exemption.

SECTION V: CATEGORICAL DETERMINATIONS

These categories allow for seven (7) calendar days for temporary admission of individuals with MI, MR, and/or RC who meet certain criteria. For emergency admission it is the responsibility of the referral source to contact DDM within two (2) business days of the admission to report the admission and to complete the *Level I* and *Level of Care screens*. Regardless of the outcome of these *Level I* and *Level of Care screens*, if the individual is determined to meet the categorical determination standards, the individual may remain in the facility for a maximum of seven (7) calendar days. If at any time it appears that the individual's stay may exceed seven (7) calendar days, and no later than the seventh (7th) calendar day, the receiving facility must update *Level I* and *Level of Care screens*. If the individual is determined not to meet medical necessity criteria, she/he must be discharged no later than the seventh (7th) calendar day.

- ***Provisional Emergency:*** Refers to immediate need for placement as a protective service measure.

- ***Provisional Delirium:*** A condition whereby the presence of delirious state precluded the ability of the referral source to determine Level I measures and there is a subsequent need to allow the delirium to clear before proceeding with that screen.

DDM Use Only. To be completed by DDM to determine whether, based on information provided by the referral source, the individual meets criteria for a categorical determination. Again, the emergency admission may be performed no later than two (2) business days following admission and the delirium category must be approved prior to admission. The DDM review nurse will supply an expiration date to correlate with the determination. It is the responsibility of the receiving facility to update that screen if at any time it appears the individual's stay will exceed seven (7) calendar days and no later than the seventh (7th) calendar day.

MAILING INFORMATION

Mailing information is required for all individuals with MI, MR, and RC

This information should be completed if the individual is suspected or confirmed as having MI, MR, or RC. All individuals with MI, MR, RC must next receive a *Level of Care screen* to determine medical eligibility before a Level II referral can be expedited. If the individual is being referred for a *Level II PASRR evaluation*, the *LOC screen* is federally required, without regard to method of payment.

DDM Summary:
This section will be completed by DDM to provide a synopsis of the *Level I screen* results. Verbal determinations will be provided to the referral source upon completion of the form and/or receipt of any requested corroborative data. The receiving facility must contact DDM to receive a copy of this form. This signed and dated form will be mailed to the receiving facility following that contact and should be kept in the individual's permanent medical record. A copy must be transferred with the individual if she/he relocates and will not require an update unless there has been a significant change in status or unless the individual was approved under a categorical or convalescent admission. A description of status changes and time limited approvals which warrant Level I updates.

LEVEL I SCREEN DETERMINATIONS

- ***Negative screens*** - Once notified by DDM that the outcome of the *Level I screen* is "*negative"* the referral source may proceed with admission to a nursing facility.

- ***Positive Level I screen*** - If DDM determines the screen is "positive" for serious MI, MR, and/or RC, the individual **may not** be admitted to a Medicaid certified nursing facility, regardless of payment source, until the *Level II PASRR evaluation* has been completed. DDM will request medical records information which supports that the individual meets criteria for a *Level II PASRR evaluation.*

- ***Level I MI/Dementia Screen Exemption*** **-** If the applicant/resident has a physician diagnosed primary Dementia **and** a co-occurring diagnosis of mental illness, the Dementia must be confirmed **primary** with supporting documentation before they are exempted form the PASRR process.

- ***Convalescent Care Exemption*** **–**Convalescent care allows the individual with MI, MR, and/or RC to be placed in a NF for 30 calendar days without performance of a *Level II PASRR evaluation.*

- **Categorical Determinations -** These categories allow for a temporary admission of seven (7) calendar days for individuals with MI, MR, and/or RC who meet certain criteria. For emergency admission it is the responsibility of the referral source to contact DDM Level I review nurses within two (2) business days of the admission to report the admission and to complete the *Level I* and *Level of Care screens*. Regardless of the outcome of these *Level I* and *Level of Care screens*, if the individual is determined to meet the categorical determination standards, the individual may remain in the facility for a maximum of seven (7) calendar days. If at any time it appears that the individual's stay may exceed seven (7) calendar days, and no later than the fifth (5th) calendar day, the receiving facility must update *Level I* and *Level of Care screens*. If the individual is determined not to meet medical necessity criteria, she/he must be discharged no later than the seventh (7th) calendar day.

Appendix B: Level of Care Instructions

Nursing home criteria are codified under NDAC 75-02-02-09 and are applicable to Medicaid eligible individuals entering (or residing in) Medicaid Certified nursing facilities, swing beds, or Home and Community based services. As part of federal PASRR guidelines, these same criteria are applied to people meeting criteria for PASRR evaluation, regardless of individual payment source, as follows:

SECTION A -- Any one of the following may demonstrate that a nursing facility level of care is medically necessary:

Criterion	Information Needed to Support LOC Need
1. The individual's nursing facility stay is or is anticipated to be temporary for receipt of Medicare Part A benefits. A NF stay may be based on this criterion for no more than fourteen days after termination of Medicare Part A benefits.	*Once the Medicare benefit period ends as a result of absence of hospital or skilled care within a designated period, continued NF care under this standard remains valid for a maximum of fourteen days following termination of Medicare part A benefits. Additional screening is required to obtain Medicaid funding for continued nursing facility placement.*
2. The individual is in a comatose state.	*A clinical state of unconsciousness where the patient is unaware of himself/herself and the environment. A "persistent vegetative state" in which the patient is wakeful but devoid of conscious content, without cognitive or effective mental function, would be included under this criterion. Documentation of either a coma or persistent vegetative state must be provided.*
3. The individual requires the use of a ventilator at least six hours per day.	*In order to warrant nursing home level of care, ventilator reliance must remain at or above six hours per day.*
4. The individual has respiratory problems that require regular treatment, observation, or monitoring that may only be provided by or under the direction of a registered nurse or in the case of a facility which has secured a waiver of the requirements of 42 CFR 483.30(b), a licensed practical nurse, and is incapable of self-care.	*Description of the individual's treatment needs and his/her capabilities. For example, an individual who uses portable oxygen at night and suffers no physical or cognitive deficits that impair the ability to self-administer would not meet this criterion.*
5. The individual requires constant help sixty percent or more of the time with at least two of the activities of daily living of toileting, eating, transferring, and locomotion. For purposes of this subdivision, constant help is required if the individual requires a caregiver's continual presence or help without which the activity would not be completed.	*The individual who meets this criterion requires the physical presence of a caregiver for toileting (use of toilet room, commode, bedpan, or urinal; cleansing; Clothing adjustment, etc), eating (feeding), transferring (movement between surfaces, i.e., to/from bed, chair, wheelchair, standing position), and locomotion (movement between locations - room to room, etc). The caregiver might provide constant instruction or cueing or the individual might require actual physical assistance to complete the tasks 6 out of 10 times the action is completed.*
6. The individual requires aspiration for maintenance of a clear airway.	*The individual requires suctioning to remove secretions from the airways.*
7. The individual has Dementia, physician-diagnosed or supported with corroborative evidence, for at least six months, and as a direct result of that Dementia, the individual's condition has deteriorated to the point where a structured, professionally staffed environment is needed to monitor, evaluate, and accommodate the individual's changing needs.	*The essential feature of a Dementia is the development of multiple cognitive deficits that include memory impairment and at least one of the following cognitive disturbances; aphasia (deterioration of language function), apraxia (impaired ability to execute motor activities despite intact motor abilities, sensory function, and comprehension of the required task), agnosia (failure to recognize or identify objects despite intact sensory function), or a disturbance in executive functioning (ability to think abstractly and to plan, initiate, sequence, monitor, and stop complex behavior). There must be documentation of a physician-diagnosed Dementia occurring at least six months prior to the screening or, in the absence of that diagnosis, evidence supporting the presence and progression of that Dementia. Descriptions of behaviors or deficits requiring a professionally staffed environment must be provided. For example, an individual diagnosed with Dementia but has no significant impairment in social or occupational functioning (school, working, shopping, dressing, bathing, handling finances, and other activities) could likely function at a lower level of care than NF.*

SECTION B -- In the absence of meeting any one criterion in Section A standards, the applicant or resident may demonstrate that a NF level of care is medically necessary if any two of the criteria are met:

Criterion	Information Needed to Support LOC Need
1. Individual requires administration of prescribed: • Injectable medication • Intravenous medication or solutions on a daily basis; or • Routine oral medications, eye drops, or ointments on a daily basis	*Both the individual's physical and cognitive abilities must be considered. For example, a 70-year-old individual with good cognitive skills and relatively good physical health might safely manage several medications including some injectable medications (i.e. Insulin), whereas a much younger individual with severe cognitive deficits might require daily assistance with medications.*
2. The individual has one or more unstable medical conditions requiring specific and individual services on a regular and continuing basis that can only be provided by or under the direction or a RN or, in the case of a facility which has secured a waiver of the requirements of 43 CFR 483.30(b), a LPN.	*Evaluation of symptom severity is highly individualized. In other words, medications or lifestyle changes may be successful in treating a particular diagnosis for one individual; however, that same diagnosis in another individual may be resistant to those interventions (e.g., brittle versus stable IDDM). Information must focus upon symptoms, required interventions, and whether interventions necessitate delivery by or under the direction of a nurse.*
3. The individual is determined to have restorative potential and can benefit from restorative nursing or therapy treatment, such as gait training or bowel and bladder training, which are provided at least five days per week.	*The individual's potential for restorative response from rehabilitation services (e.g., physical, occupational, speech therapy, etc.) is the focus of assessment. In this sense, restorative suggests an expectation that, with and as a result of the services, the individual will regain skills or avoid significant deterioration, and those services must and should be delivered by a qualified professional no less than five days per week. Routine maintenance services are not included.*
4. The individual requires administration of feedings by nasogastric tube, gastrostomy, jejunostomy, or parenteral route.	*The individual receives nourishment via a gastrointestinal or intravenous tube. Either route of administration requires nursing intervention to monitor intake and output (I&O), residual results, correct tube placement, etc.*
5. The individual requires care of decubitus ulcers, stasis ulcers, or other widespread skin disorders.	*This criterion references skin disorders that have a potential detrimental effect on an individual's physical health. While decubiti, for example, can very quickly lead to very serious outcomes without aggressive treatment, many skin disorders, while unpleasant, pose little threat to physical health (dermatitis, etc) and would not require NF level of care.*
6. The individual requires constant help sixty percent or more of the time with any one of the activities of daily living of toileting, eating, transferring, or locomotion. For purposes of this subdivision, constant help is required if the individual requires a care giver's continual presence or help without which the activity would not be completed.	*See Section A*

SECTION C –If no aforementioned criteria are met, an individual who applies to or resides in a nursing facility designated as a facility for nongeriatric individuals with physical disabilities may demonstrate that a nursing facility level of care is medically necessary if the individual is determined to have restorative potential.

Criterion	Information Needed to Support LOC Need
*The focus must be directed at potential for restoration/improvement as a basis for admission to specialty facilities treating non-geriatric, physically handicapped individuals who are not seeking medical care alone. Specific services **must** be identified.*	

SECTION D – If no criteria are met, an individual who applies for NF care may demonstrate that a nursing facility level of care is medically necessary if:

Criterion	Information Needed to Support LOC Need
The individual has an acquired brain injury, including anoxia, cerebral vascular accident, brain tumor, infection, or traumatic brain injury –and- As a result of the brain injury, the individual requires direct supervision at least eight hours a day.	

Appendix C: Tracking Form

Appendix D: Medicaid Payment Alert Form

Appendix E: Screening Quick Reference Sheet

NORTH DAKOTA SCREENING RULES

Client Status	Level of Care Screen (Document)	Level I
NF Applicant (Medicaid/Medicaid Applicant) ***including ND Medicaid moving to Minnesota NF***	YES	Yes
NF Applicant (Non-Medicaid)	Only if Level I identifies suspected or known MI or MR/RC	YES
NF Resident (Medicaid or Medicaid Applicant)	Only if: ✓ CSR (potential for improvement) ✓ LOC is questionable or no longer met ✓ Level II Status Change ✓ Time limited stay has ended & continued stay is desired	Only if: ✓ Resident with MI or MR/RC experiences change in status ✓ Resident with newly identified MI or MR/RC ✓ Resident with MI or MR/RC Short term approval ends
NF Resident (Non-Medicaid)	Only if: ✓ Resident with MI or MR/RC ✓ Medicaid Applicant	Only if: ✓ Resident with MI or MR/RC experiences change in status ✓ Resident with newly identified MI or MR/RC ✓ Resident with MI or MR/RC Short term approval ends
NF Resident transferring (Medicaid or Medicaid Applicant) (from NF to NF or NF-Hosp-NF)	Only if: ✓ No LOC approval within 90 days ✓ LOC changed – possibly no longer meets LOC for NF/SB.	Only if: ✓ Resident with MI or MR/RC & change in status ✓ Resident with newly identified MI or MR/RC
NF/SB Resident transferring (Non-Medicaid) (from NF/SB to NF/SB or NF/SB-Hosp-NF/SB)	Only if: ✓ Resident has MI or MR/RC ✓ Resident is a Medicaid Applicant	Only if: ✓ Resident with MI or MR/RC and change in status ✓ Resident with newly identified MI or MR/RC
Swingbed Applicant (Medicaid)	YES	NO
Swingbed Resident (Medicaid) (from SB to SB or SB -Hosp-SB)	Only if ✓ CSR (potential for improvement); ✓ LOC is questionable or no longer met	NO
Swingbed Applicant or Resident (non-Medicaid)	NO	NO
Swingbed Transfer (Medicaid)	Only if: ✓ Not approved for SB LOC within 90 days	NO
Basic Care Beds/Facilities (applicants)	NO	NO
HCBS Applicant	YES	NO
HCBS Recipient	YES ✓ 2 months prior to end date ✓ As a termination review	NO
***Administrative* - Expired/discharged resident (Medicaid status unknown at death discharge)**	YES (as requested)	NO
TBI Applicant	YES	NO
TBI Recipient	YES ✓ 2 months prior to end date ✓ As a termination review	NO

Appendix F: Level of Care and Level I Forms